JAMES H. JANG DDS PLLC
Comprehensive Family, Cosmetic and Implant Dentistry
725 Oswego Street, Liverpool, NY 13088
T / F: 315 457 4262

Patient Registration Form

(Please Print)

Date:_____

PATIENT INFORMATION

First Name:	Last:	M.I.:	Marital Status: Single I Married I Child Other: _____
Address:	City:	State:	Zip:

SSN #:	Driver's Lic. #:	Date of Birth:	Age:	Sex: M / F

Please prioritize the best way to reach you. (e.g. 1 to 4)

___ Home #:	___ Cell #:	___ Work #: EXT:	___ Email:

Occupation:	Employer / School:	Employer / School phone #:

Who may we thank for referring you? Family I Friend I Internet I Close By/Drive By I Other:

ACCOUNT INFORMATION

Person Responsible for Payment:	Date of Birth:	Phone #:
Address (if different):	SSN #:	Relationship to Patient:

Occupation:	Employer:	Employer Address:	Employer Phone #:

Is this person a patient here? Yes / No

INSURANCE INFORMATION

Primary Insurance:	Subscriber ID #:	Group #:	Employer:
Subscriber's Name:	Subscriber's SSN #:		Subscriber's Date of Birth:

Patient's relationship to subscriber: Self I Spouse I Child I Other:

Secondary Insurance (if applicable):	Subscriber ID #:	Group #:	Employer:
Subscriber's Name:	Subscriber's SSN #:		Subscriber's Date of Birth:

Patient's relationship to subscriber: Self I Spouse I Child I Other:

IN CASE OF EMERGENCY

Person to contact for emergency:	Cell #:	Home #:	Work #:
Address:		Relationship to patient:	

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to James H. Jang DDS PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance information. The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Patient, Parent, Guardian or Responsible Party — Date

Please print name of Patient, Parent, Guardian or Responsible Party — Relationship to Patient

JAMES H. JANG DDS PLLC
general | cosmetic | implant dentistry
adult | pediatric orthodontics
iv | inhalation sedation

725 Oswego Street
Liverpool, NY 13088
t/f: (315) 457-4262

jamesjangdds@gmail.com
www.jamesjangdds.com

OUR OFFICE PAYMENT POLICY

PLEASE READ CAREFULLY

Forms of Payments:
We accept cash, checks, Visa, MasterCard, AmericanExpress, Discover and CareCredit. All returned checks will be assessed a $30.00 fee to the patient's account.

Non-Insurance Patients:
Payment in full is required the day services are rendered unless prior arrangements have been made.

Insured Patients:
- We do not participate with a specific insurance plan, however, as a courtesy, we can submit your insurance claims for you.
- **New Patients:** until the insurance is verified, payment in full is required the day services are rendered.
- **Co-payments and Deductibles:** will be estimated by our office and are to be paid in full at the time of service. If the patient does not agree to the specific co-payment and/or co-insurance, then James H. Jang DDS PLLC will not accept the patient's insurance assignment of benefits. The patient shall pay the entire cost of treatment and submit his or her own dental claim.
- **When benefits are not assignable to our office:** the patient will be expected to pay the cost of treatment in full at the time of service, and the insurance payment will be paid directly to the patient.
- Dental services are provided and charged to the patient and not the insurance company. Outstanding balances resulting from under payments from insurance company will be the responsibility of the patient.
- It is NOT the responsibility of James H. Jang DDS PLLC to collect on any outstanding insurance claims or to negotiate a settlement on a disputed claim as this is solely the patient's responsibility.
- After 60 days from the treatment date, any unpaid balances will be due in full from the patient or the responsible party. Finance charges will accrue to all outstanding balances.

Crowns or Dental Appliances:
We will collect 50% of the cost of any crowns or dental appliances on the day impressions are taken. This is necessary to cover the lab fee. The remaining balance is due upon the delivery of the crowns/appliances.

Emergency Patients:
If insurance is not verifiable at the time of service, then full payment is expected at the time of service.

Financing and Collections:
- Interest-free financing is available through Care Credit. Please ask for details.
- We offer 5% courtesy discount for services paid in full on treatment day by cash or check.
- A minimum late fee of $10.00 or 1.5% interest will accrue on all outstanding balances after 60 days.
- If you are making monthly payments on our account, you will still accrue either an interest charge or late fee.

- If an account has gone unpaid for 90 days or more, the account will be released to a collection agency, unless other arrangements have been made in **writing** and agreed upon by both account holder and James H. Jang DDS PLLC.
- If an account is sent to collection, there will be a $50.00 processing fee charged to the account.

Cancellations and Missed Appointments:
There is a $40.00 fee charged to the patient's account without a 24-hour cancellation notice.

Important Note:
Please keep our office informed of any changes to your personal information or insurance information in order to help us better serve you.

Please feel free to ask if you have any questions.

I have read, understood and accept the terms of the payment policy.

Signature of Patient, Parent, Guardian or Responsible Party	Date	Patient's Name (if minor)
Please print name of Patient, Parent, Guardian or Responsible Party	Relationship to Patient	

DENTAL HISTORY

Name _____ Nickname _____ Age _____
Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam _____ /_____ /_____ Date of most recent x-rays _____ /_____ / _____
Date of most recent treatment (other than a cleaning) _____ / _____ / _____
I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____
2. Have you had an unfavorable dental experience? _____
3. Have you ever had complications from past dental treatment? _____
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? _____

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____
10. Is there anyone with a history of periodontal disease in your family? _____
11. Have you ever experienced gum recession? _____
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____
18. Do you have grooves or notches on your teeth near the gum line? _____
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____
20. Do you frequently get food caught between any teeth? _____

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? _____
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____
25. Are your teeth becoming more crooked, crowded, or overlapped? _____
26. Are your teeth developing spaces or becoming more loose? _____
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? __
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____
30. Do you clench or grind your teeth together in the daytime or make them sore? _____
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? ___
32. Do you wear or have you ever worn a bite appliance? _____

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change (shape, color, size)? _____
34. Have you ever whitened (bleached) your teeth? _____
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____
36. Have you been disappointed with the appearance of previous dental work? _____

Patient's Signature _____ Date _____
Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? Excellent Good Fair Poor

DO YOU HAVE or HAVE YOU EVER HAD: **YES NO**

1. hospitalization for illness or injury _____
2. an allergic or bad reaction to any of the following:
   - aspirin, ibuprofen, acetaminophen, codeine
   - penicillin
   - erythromycin
   - tetracycline
   - sulfa
   - local anesthetic
   - fluoride
   - metals (nickel, gold, silver, _____)
   - latex
   - nuts _____
   - fruit _____
   - other _____
3. heart problems, or cardiac stent within the last six months ___
4. history of infective endocarditis _____
5. artificial heart valve, repaired heart defect (PFO) _____
6. pacemaker or implantable defibrillator _____
7. orthopedic implant (joint replacement) _____
8. rheumatic or scarlet fever _____
9. high or low blood pressure _____
10. a stroke (taking blood thinners) _____
11. anemia or other blood disorder _____
12. prolonged bleeding due to a slight cut (INR > 3.5) _____
13. pneumonia, emphysema, shortness of breath, sarcoidosis ___
14. tuberculosis, measles, chicken pox _____
15. asthma _____
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)
17. kidney disease _____
18. liver disease _____
19. jaundice _____
20. thyroid, parathyroid disease, or calcium deficiency _____
21. hormone deficiency _____
22. high cholesterol or taking statin drugs _____
23. diabetes (HbA1c = _____) _____
24. stomach or duodenal ulcer _____
25. digestive or eating disorders (e.g., celiac disease, gastric reflux, bulimia, anorexia) _____

YES NO

26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ___
27. arthritis _____
28. autoimmune disease _____
    (i.e. rheumatoid arthritis, lupus, scleroderma)
29. glaucoma _____
30. contact lenses _____
31. head or neck injuries _____
32. epilepsy, convulsions (seizures) _____
33. neurologic disorders (ADD/ADHD, prion disease) _____
34. viral infections and cold sores _____
35. any lumps or swelling in the mouth _____
36. hives, skin rash, hay fever _____
37. STI/STD/HPV _____
38. hepatitis (type ____) _____
39. HIV/AIDS _____
40. tumor, abnormal growth _____
41. radiation therapy _____
42. chemotherapy, immunosuppressive medication _____
43. emotional difficulties _____
44. psychiatric treatment _____
45. antidepressant medication _____
46. alcohol/recreational drug use _____

ARE YOU:

47. presently being treated for any other illness _____
48. aware of a change in your health in the last 24 hours
    (i.e. fever, chills, new cough, or diarrhea) _____
49. taking medication for weight management _____
50. taking dietary supplements _____
51. often exhausted or fatigued _____
52. experiencing frequent headaches _____
53. a smoker, smoked previously or use smokeless tobacco ___
54. considered a touchy/sensitive person _____
55. often unhappy or depressed _____
56. taking birth control pills _____
57. currently pregnant _____
58. diagnosed with a prostate disorder _____

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)